General SD – Initial Visit
Patient Questionnaire
Men's Health Center

Today's Date: ___/___/___

LAST NAME: _____ FIRST NAME: _____ DOB: _____

CC: Why are you here? Check all that apply

Problems obtaining or maintaining erections
- [ ] Firm erections that don't last
- [ ] Partial erections
- [ ] No erections at all

Can you penetrate? [ ] Yes [ ] No

Ejaculation or orgasm problems
- [ ] ejaculate too soon
- [ ] unable to or it is difficult to ejaculate or achieve orgasm
- [ ] I achieve orgasm normally but very little fluid is produced
- [ ] I achieve orgasm normally but the intensity or pleasure is reduced

[ ] Erection is curved

[ ] Low testosterone

[ ] I have low or no interest in having sex

[ ] Other: Please explain:_____

HPI: Age: _____ How long have you had this problem? _____

Are you: Heterosexual ( ) Homosexual ( ) Bisexual ( )
Married [ ], how long? ____ Divorced [ ] how long? ____ Separated [ ] how long? ____
Single and never married [ ] Widowed [ ] how long? _____

If you are single, do you have a steady sexual partner?
No [ ]
Yes [ ], if so how long have you been with your current partner? _____
Age of partner _____

For physician only:

Name: _____ Dob: _____

Is there any stimulation that produces a firm erection? ☐ Yes ☐ No

If yes, what type of stimulation?

☐Masturbation ☐Oral

☐Manual with partner ☐Erotic films, videos, magazines

☐Other, explain: _____

Are you able to penetrate? ☐ Yes ☐ No

Do you wake up with erections? ☐ No ☐ Rarely ☐ Occasional ☐ Frequent

Does your penis have a bend to it when it is erect? ☐ Yes ☐ No

If your penis does bend:

How many degrees is the bend?

☐ $0^o – 10^o$ ☐ $>10^o – 30^o$ ☐ $>30^o – 60^o$ ☐ $>60^o – 90^o$ ☐ $>90^o$

Which direction does it bend?

☐ Up ☐ Down ☐ Right ☐ Left

☐ Up and right ☐ Up and left ☐ Down and right ☐ Down and left

How long have you had the bend? _____Have you injured your penis ☐Yes ☐ No

If you obtain an erection, is it painful? ☐ Yes ☐ No

Do you have a problem with ejaculation or orgasm? ☐ Yes ☐ No

If yes, please answer the following questions:

☐ I ejaculate too quickly

☐ Before penetration ☐ Less than 1 minute after penetration

☐ 1 – 5 minutes after penetration ☐ More than 5 minutes after penetration

☐ It takes me too long to achieve orgasm or I can't achieve orgasm

Is there any stimulation that causes orgasm? _____

☐I achieve orgasm normally but very little fluid is produced.

☐I achieve orgasm normally but the intensity or pleasure is reduced.

If you have a low testosterone, when was it diagnosed? _____,

Have you had testosterone replacement? ☐ Yes ☐ No

What treatment have you had: _____

For physician use:

Name: _____ Dob: _____

For physician only: Current SHIM score without treatment: _____
severe (5 to 7), moderate (8 to 11), mild to moderate (12 to 16), mild (17 to 21), and no ED (22 to 25)

Which if any treatments have you had for your problem?

☐	Oral	☐Viagra, Dose: _____ ☐ Cialis, Dose: _____ ☐ Levitra, Dose: _____
		Results: *SHIM score:*
☐	MUSE	Results: *SHIM score:*_____
☐	Gel	3p gel ☐LD ☐MD ☐HD ☐Super HD BiGel ☐LD ☐HD PGE1☐ ☐Custom:_____ Results:
☐	Penile Injection	☐ Edex or Caverject or Prostaglandin ☐ Standard Triple mixture ☐ Super Triple mixture ☐ Other or BiMix
		Results *SHIM score:*
☐	Vacuum Device	Results:
☐	Surgery	Describe:
		For Physician use:
☐	Sexual counseling	
☐	Testosterone	Details:
☐	Other	Describe:

Generally, how satisfied are you with the overall sexual relationship you have with your main partner? Would you say you are… (check only one) MSHQ 27 (36)

☐ Extremely satisfied ☐ Moderately satisfied ☐ Moderately unsatisfied
☐ Neither satisfied nor unsatisfied ☐ Extremely unsatisfied

Generally, not counting your sexual relationship, how satisfied are you with all other aspects of the relationship you have with your main partner? Would you say you are… (check only one) MSHQ 32

☐ Extremely satisfied ☐ Moderately satisfied ☐ Neither satisfied nor unsatisfied
☐ Moderately unsatisfied ☐ Extremely unsatisfied

Allergies Name: _____

Are you allergic to any medications? ☐Yes ☐No Dob: _____

If yes, which medications and what was the reaction?

Medication	Reaction
1)	
2)	
3)	

Medications

Do you take any medicine containing nitrates or nitroglycerine? ☐Yes ☐No

List any medications or health supplements you take.

PAST MEDICAL HISTORY: Check off any medical conditions that you have:

(51)

☐	High blood pressure	☐	Disc disease of the Neck
☐	Diabetes	☐	Disc disease in Thoracic spine (upper back)
☐	High cholesterol	☐	Disc disease in Lower (Lumbar\sacral) back
☐	Heart Attack	☐	Multiple Sclerosis
☐	Angina (heart pain)	☐	Parkinson's Disease
☐	Heart bypass surgery	☐	Thyroid disease
☐	Coronary stent for heart	☐	Low testosterone
☐	Blood vessel disease in legs (peripheral vascular disease)	☐	Prostate cancer surgery
☐	Bypass surgery for blood vessels in the legs	☐	Bladder cancer surgery
☐	Prostate surgery – NOT for cancer	☐	Bowel or Rectum cancer surgery
☐	Stroke (CVA)	☐	Radiation therapy to prostate, bladder or bowels
☐	Carotid artery (artery in the neck) surgery	☐	Pelvic fracture
☐	Depression	☐	HIV
☐	Anxiety	☐	Hepatitis B
☐	Priapism (prolonged erection0	☐	Hepatitis C
☐	Neurological Problems	☐	Any sexually transmitted diseases

Name: _____ Dob: _____

List any other medical diseases or conditions: _____

_____

Have you had any of the following?:

☐ Robotic prostatectomy ☐ Open radical prostatectomy for cancer
Date: _____ Surgeon: _____

☐ Removal of bladder (cystectomy, cystoprostatectomy)
Date: _____ Surgeon: _____

☐ Radiation therapy to the pelvis, prostate, or bladder
Date: _____ Radiation Doctor: _____

☐ Brachytherapy (radioactive seeds in the prostate for cancer)
Date: _____ Surgeon: _____

☐ Rectal or other pelvic surgery
Date: _____ Surgeon: _____

If you have had any of the above procedures,

Did you have any erection problems before the procedure: ☐ Yes ☐ No
Has your penis become smaller since the procedure?

While flaccid (soft): ☐ Yes ☐ No

While erect: ☐ Yes ☐ No ☐ I Don't Know – I am not getting erections

Without the use of medication (pills, MUSE, or injections) how firm were your erections prior to the procedure? ☐ Use the following scale:

1 = Completely flaccid/soft
2 = Partially hard but not hard enough to penetrate
3 = Just hard (firm) enough to penetrate
4 = Plenty hard for penetration but not completely hard
5= Completely hard

List any other surgeries and dates: _____

_____

_____

Name: _____ Dob: _____

Social History

Check all that apply

Cigarettes ☐ I currently smoke ☐ I used to smoke ☐ I never smoked
How many packs per day do you or did you smoke? _____ for how many years? _____

☐ No alcohol ☐ 0 – 1 drink per day ☐ 2 – 3 drinks per day ☐ 4 or more drinks per day

☐ Marijuana ☐ Other – list: _____

Exercise: ☐ None ☐ Weekly ☐ Daily

☐ Aerobic (such as jogging, walking, bicycling, swimming, etc)

Can you walk up one flight of stairs without chest pain ☐ Yes ☐ No

Family History

Check all that apply

☐ High blood pressure	☐ Depression
☐ Diabetes	☐ Stroke
☐ High cholesterol	☐ Heart Attack
☐ Prostate Cancer	☐ Other: list:

For physician use:

Prior Lab results:

Review of Systems Name: _____ Dob: _____

Check off all that apply

System	Symptom	Yes	No	Notes
General	Fever	☐	☐	
	Weight loss	☐	☐	
Neuro	Headaches	☐	☐	
	Weakness in arms or legs	☐	☐	
Eyes	Vision problems	☐	☐	
CV	Angina	☐	☐	
	Irregular heart beat	☐	☐	
Respiratory	Cough	☐	☐	
	Shortness of breath	☐	☐	
	Coughing up blood	☐	☐	
GI	Nausea	☐	☐	
	Vomiting	☐	☐	
	Abdominal pain	☐	☐	
	Rectal Bleeding	☐	☐	
GU	Burning with urination	☐	☐	
	Blood in urine	☐	☐	
	Incontinence of urine	☐	☐	
	Urinate too frequently	☐	☐	
MS	Joint pain	☐	☐	
Psych	Anxiety or Depression	☐	☐	
Heme	Anemia	☐	☐	
	Swollen lymph glands	☐	☐	
Skin	Rash	☐	☐	
Endo	Heat or cold intolerance	☐	☐	
	Excessive thirst	☐	☐	
	Hot flashes	☐	☐	

Name: _____ Dob: _____

Physician use only: (comments/notes)

If cystoprostatectomy: Path stage: _____

☐ Conduit ☐ Continent diversion ☐ Neobladder

☐ Chemo ☐ Radiation

Pelvic Radiation

☐ Prostate ☐ Bladder ☐ Other: _____

Type: ☐ IMRT ☐ Unknown ☐ Brachy

Antiandrogens: ☐ Temporary, duration: _____ ☐ Still using

Rectal or other pelvic surgery: Type: _____

☐ Neoadjuvant chemo ☐ Adjuvant chemo ☐ Neoadjuvant RT ☐ Adjuvant RT

For Peyronies:

Dupuytren's contracture: ☐ Yes ☐ No

Penile Trauma: ☐ Yes ☐ No

First sign: ☐ Chordee ☐ Nodule ☐ Pain

Prior Treatments: ☐ None ☐ Oral ☐ TD ☐ IL ☐ Surgery

☐ Other: _____

Waist ☐ Yes ☐ No

Instability ☐ Yes ☐ No

Penetration ability ☐ Yes ☐ No

I have personally reviewed the above history and have discussed it with the patient

_____ Date: _____

Mark Sigman, MD

I have personally reviewed the above history and have discussed it with the patient

_____ Date: _____

Martin Miner, MD